



REQUISITION FORM FOR PHARMACOLOGICAL SCREENING

NAME: <input type="text"/>		For Office Use Only	
DESIGNATION: <input type="text"/>		Reference No. <input type="text"/>	
ADDRESS: <input type="text"/>		DATE: / /	
TEL. / MOBILE NO.: <input type="text"/>	EMAIL: <input type="text"/>		
WHAT SORT OF SAMPLES: <input type="text"/>	NO. OF SAMPLES: <input type="text"/>		
SOLVENT: <input type="text"/>			
CONTROL (REF. DRUG): <input type="text"/>			
SPECIES OF ANIMALS: <input type="text"/>			
- General Screening <input type="checkbox"/>		- Local Anesthetic <input type="checkbox"/>	
- Antiarrhythmic <input type="checkbox"/>		- Anti-hypertensive <input type="checkbox"/>	
- Analgesic, Antipyretic <input type="checkbox"/>		- Anti-Spasmodic <input type="checkbox"/>	
- Neuromuscular junction blocking <input type="checkbox"/>		- C.N.S stimulant <input type="checkbox"/>	
- C.N.S depressant <input type="checkbox"/>		- Anti-consultant <input type="checkbox"/>	
- Anti- Diabetic <input type="checkbox"/>		- Anti-inflammatory <input type="checkbox"/>	
- Others <input type="checkbox"/>			
<input type="text"/>			
SIGNATURE		DATE: / /	
<input type="text"/>			